

FILED OCT 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35496
State File No. 8997
Registrar's No.

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	d. STREET ADDRESS (If rural, give location) 3448 Illinois Ave
d. FULL NAME OF HOSPITAL OR INSTITUTION 3448 Illinois Ave			

3. NAME OF DECEASED a. (First) F. W. August (Type or Print) b. (Middle) Rauch c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 10-18-1949			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH 12-10-1871	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Brewery Worker	11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Deceased
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 488-18-6335	17. INFORMANT'S SIGNATURE OR NAME Frieda Noll	ADDRESS 6924 Hillland Ave
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer (Carcinoma) of Esophagus		INTERVAL BETWEEN ONSET AND DEATH 6 mo.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Involving Lungs.		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION no	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) How
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 1:50 P	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 150 X
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22. I hereby certify that I attended the deceased from **Apr 12th, 1949**, to **Oct. 18, 19 49** that I last saw the deceased alive on **Oct. 17, 19 49**, and that death occurred at **2:45 P m.**, from the causes and on the date stated above.

23a. SIGNATURE (Type or Print) H. H. Walters M.D.	23b. ADDRESS 3608 South Grand Blvd.	23c. DATE SIGNED 10/19/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-21-1949	24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	24d. LOCATION (City, town, or county) (State) 10180 Gravois Ave. Mo
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DATE REC'D BY LOCAL REG. OCT 19 1949	REGISTRAR'S SIGNATURE J. B. Basater	25. FUNERAL DIRECTOR'S SIGNATURE Diegenheim Bros	ADDRESS 6409 Gravois Ave
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Mary - Esophagus IA 7891 to 4

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed

Henry M. Brammer

Licensed Embalmer No. *4200*

P. O. Address. *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.